Patient Introduction

Personal History:

Name: _____
First Middle Last

E-mail address: _____
Complete Address:
_____
_____
_____

Telephone: Home:_____ Cell: _____Bus:_____

Emergency Contact _____(Phone):_____

Insurance Card: _____
(Please bring health card to front desk)

SS#_____

Birth Date: Month: _____ Day: _____ Year: _____

Age: _____

Marital Status:_____

Occupation: _____

Employer: _____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor:_____

Reason for leaving:
_____
_____
_____

Present MD: _____ City: _____

Referred to our Centre by:_____

Adult Consultation History

Your Name: _____

Your Main Complaint: _____
_____

Any other Complaints: _____
_____
_____
_____

How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____
_____
_____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____
_____
_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

How does handling this problem cause stress for you? _____

_____

_____

What do you do that makes this problem worse? _____
_____
_____

How much older does this make you feel: _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

Adult Consultation History Continued

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ____ Intermittent ____ Occasional ____ Cyclic ____

What is the effect it has on your body functions? _____

How and when did it start? _____

_____

Are you on any type of medication? _____ Please list all: _____

_____

_____

Could your problem have been caused by an injury at work? _____

If yes, please give us the details: _____

_____

_____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this: _____

_____

_____

_____

Do you have any children? YES _____ NO ____

Do they have any health problems that you are aware of? _____

_____

Is there any other information you would like us to know? _____

_____

_____

_____

SIGNATURE: _____ DATE: _____

For Women Only

Date of your last menstrual period: _____

Are you using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Do you suffer from PMS? _____